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THE CULTURAL DIMENSIONS OF ALCOHOL POLICY WORLDWIDE

by Diana Chapman Walsh, Philip J. Cook, Karen Davis, Marcus Grant, Pekka Sulkunen, George E. Vaillant, and Thomas L. Delbanco

Prologue: The complex mixture of ideology, morality, politics, and culture involved in any discussion of alcohol policy has led some to call it a “dogma-eat-dogma” world. An international symposium on the topic in 1986 reflected not only a single nation’s various views on alcohol policy, but the views of twenty-one nations. This symposium was the 248th session of the Salzburg Seminars, a series of private, nonprofit seminars held since World War II on a wide range of social policy topics. The seven authors of this article served as faculty for the two-week-long seminar, which had over forty participants. The article, summarizing the consensus reached at the seminar, uses the worldwide perspective to inform American alcohol policy. Such a perspective reveals how differences in culture and political tradition affect the most basic definition of problems and potential solutions. Diana Chapman Walsh, at Boston University, is a university professor, professor of public health, and associate director of the School of Public Health’s Health Policy Institute. Philip Cook directs the Institute of Policy Sciences and Public Affairs at Duke University in Durham, North Carolina. Karen Davis is chair of the Department of Health Policy and Management at The Johns Hopkins School of Hygiene and Public Health, and is a professor of political economy at The Johns Hopkins University in Baltimore, Maryland. Marcus Grant is a senior scientist in the World Health Organization’s Division of Mental Health, Geneva, Switzerland. Pekka Sulkunen is director of the Social Research Institute of Alcohol Studies in Helsinki, Finland. George Vaillant is a professor at Dartmouth Medical School, Hanover, New Hampshire. Thomas Delbanco, who chaired the Salzburg Seminar session, is director of general medicine and primary care in the Department of Medicine of Boston’s Beth Israel Hospital, and is an associate professor of medicine at Harvard Medical School.
However much the American public may worry about illicit drug use, it remains both true and generally acknowledged that alcohol, a legal drug, costs a great deal more in whatever metric applied: medical, social, economic, or public health. On the one hand, strikingly little is known about how to manage a health and social problem whose consequences are as palpable as are those associated with alcohol abuse. On the other hand, a knowledge base on the effects of alcohol is being built, some practical lessons are emerging, and avenues are opening up for further investigation and understanding of how to confront a wide range of problems associated with alcohol, its use, and its abuse.

One increasingly important source of insight is an international perspective, compelling attention as it does to culturally specific constraints on social policy as well as enduring regularities that transcend national boundaries. Several seminal contributions to the comparative investigation of alcohol problems have been completed in recent years. Drawing on that research and on an intensive two-week seminar in Salzburg, Austria, involving participants from twenty-one nations, this article places the alcohol problem in an international perspective and extracts selected lessons for policy in the United States.

Comparisons across countries reveal the central role played by cultural factors not only in the way alcohol is used and regulated around the world but also in the very definition of the nature, extent, and source of subsequent problems. A Moroccan or Israeli man is labeled an incipient problem drinker if he averages more than two beers a week at anything other than formal social occasions, and a Sri Lankan woman seems abnormal if she drinks at all. In Ireland, Finland, and elsewhere, drinking (at least in public) was a male prerogative until after World War II. Around the world, women in large numbers have taken up drinking in recent decades, although at rates of per capita consumption still below those of men. Citizens of Spain, Italy, Malta, France, and other wine-growing countries have long looked on wine as a food and a source of physical and social sustenance for both sexes on many occasions, beginning at an early age.

For a polyglot society like the United States, cultural factors such as these create a pastiche of competing definitions and values that frustrate attempts to build consensus or comprehensive policy. Americans therefore can learn much from a cross-cultural exploration of styles of alcohol use, perceptions of associated problems, and attitudes toward control. Two main lessons stand out from international comparisons. First, effective alcohol policy must take account of tensions between health considerations and political, economic, and social forces, as well as deeper
cultural meanings attached to alcohol and its use. Second, a wide range of policy options can be subsumed in a general analytic framework that highlights the levers and the targets of efforts to control the harmful effects of alcohol.

Cultural Versus Political Forces

In any society, two forces place constraining pressure on policy. The first force is cultural attitudes toward alcohol, viewed in some societies as a basic daily commodity, with a social meaning and an important positive role in most people’s lives. The wine-producing countries of southern Europe, in particular, perceive alcohol this way. In other cultures, alcohol is considered a dangerous drug and an appropriate target for resolute state controls. A history of vigorous temperance activity, as in Sweden, Norway, Finland, Switzerland, England, and the United States, is one indicator of such an attitude, and religious strictures are often an important underlying factor. The second force is political systems, which differ fundamentally in relationships they assume or establish between citizens and state. Here the continuum runs from strong state intervention to a premium on individual autonomy and self-control. Government controls on alcohol distribute distinctively along these two dimensions. Political ideologies, robust as they ordinarily are, can be overridden by the cultural position of alcohol in a given society at a particular historical point.

Cultures that fear alcohol as an insidious drug evolve powerful rituals, taboos, and social norms to control its use. But forces of urbanization and modernization tend to wear down these cultural brakes. In countries where this is occurring, official bureaucratic controls on alcohol are more readily accepted than they are in societies where alcohol is integral to the fabric of everyday life and commerce. To Italians, for example, the idea of raising the legal drinking age is anathema; if pressed for a strategy to reduce alcohol-related highway deaths, they will argue instead for restrictions on access to high-horsepower vehicles. In affluent societies, alcohol is deeply embedded in the economy and in the distinction system of status-oriented consumption. In recent years, some countries have striven to adopt a middle position. France, a wine-producing country that has had high rates of alcoholism and liver disease, is seeking to modify but not eliminate drinking. Countries with temperance traditions—notably the United States, England, and the Scandinavian countries—have been focusing on problems related to alcohol, such as highway fatalities, and also have sought to expand and elaborate available resources for treating alcoholics. Nevertheless, patterns of use, and also policy options, in any
one country and around the world are influenced by these historical forces, combined with economic factors.

**Global alcohol consumption.** Statistics on global alcohol consumption have shown a steady upward trend over the past twenty years, with the greatest growth in the countries that began from a lower base (Exhibit 1).\(^2\) The increase may reflect the attenuation of formal controls with the waning of temperance thinking throughout the Western world and also a decrease in the real price of alcoholic beverages as inflation has eroded the effect of taxes. Still more fundamental are the social, economic, and demographic variables that have created new cohorts of drinkers, new locations and occasions for drinking, and new types of alcoholic beverages.

### Exhibit 1
**Per Capita Consumption. In Liters Of Absolute Alcohol. Various Countries**\(^a\)

<table>
<thead>
<tr>
<th>Country</th>
<th>1950-1952(^b)</th>
<th>1960(^c)</th>
<th>1968-1970(^b)</th>
<th>1980(^c)</th>
<th>1985(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>6.4(^c)</td>
<td>6.2</td>
<td>8.2</td>
<td>9.9</td>
<td>-</td>
</tr>
<tr>
<td>Austria</td>
<td></td>
<td></td>
<td>10.8</td>
<td>11.0</td>
<td>12.7</td>
</tr>
<tr>
<td>Belgium</td>
<td>6.6</td>
<td>6.2</td>
<td>8.4</td>
<td>9.8</td>
<td>16.7</td>
</tr>
<tr>
<td>Canada</td>
<td>4.9</td>
<td>5.8</td>
<td>6.4</td>
<td>9.2</td>
<td>-</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>4.9(^e)</td>
<td>5.7</td>
<td>8.2</td>
<td>9.8</td>
<td>12.6</td>
</tr>
<tr>
<td>Denmark</td>
<td>4.0</td>
<td>4.1</td>
<td>7.0</td>
<td>9.2</td>
<td>12.8</td>
</tr>
<tr>
<td>Federal Republic of Germany</td>
<td>3.6</td>
<td>7.0</td>
<td>10.1</td>
<td>12.7</td>
<td>13.2</td>
</tr>
<tr>
<td>France</td>
<td>17.6</td>
<td>17.2</td>
<td>16.1</td>
<td>14.8</td>
<td>16.6</td>
</tr>
<tr>
<td>German Democratic Republic</td>
<td>1.9</td>
<td>4.7</td>
<td>6.0</td>
<td>9.5</td>
<td>12.9</td>
</tr>
<tr>
<td>Hungary</td>
<td>4.8</td>
<td>6.1</td>
<td>8.9</td>
<td>11.4</td>
<td>15.0</td>
</tr>
<tr>
<td>Ireland</td>
<td>3.4</td>
<td>3.2</td>
<td>4.4</td>
<td>7.5</td>
<td>9.5</td>
</tr>
<tr>
<td>Italy</td>
<td>9.4</td>
<td>12.0</td>
<td>13.7</td>
<td>14.8</td>
<td>15.8</td>
</tr>
<tr>
<td>Luxembourg(^f)</td>
<td>6.8</td>
<td>8.1</td>
<td>9.4</td>
<td>18.5</td>
<td>22.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5.6(^e)</td>
<td>3.8</td>
<td>5.3</td>
<td>9.0</td>
<td>11.3</td>
</tr>
<tr>
<td>New Zealand</td>
<td></td>
<td>3.8</td>
<td>5.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>3.1</td>
<td>6.5</td>
<td>7.3</td>
<td>9.0</td>
<td>8.6</td>
</tr>
<tr>
<td>Portugal</td>
<td>12.9(^e)</td>
<td>11.0</td>
<td>15.2</td>
<td>11.1</td>
<td>18.7</td>
</tr>
<tr>
<td>Romania</td>
<td>4.7(^e)</td>
<td>4.0</td>
<td>6.3</td>
<td>7.9</td>
<td>10.7</td>
</tr>
<tr>
<td>Spain</td>
<td>8.1</td>
<td>8.5</td>
<td>11.9</td>
<td>14.0</td>
<td>17.4</td>
</tr>
<tr>
<td>Switzerland</td>
<td>6.6</td>
<td>9.9</td>
<td>10.3</td>
<td>10.5</td>
<td>13.7</td>
</tr>
<tr>
<td>Turkey</td>
<td>0.3</td>
<td></td>
<td>0.4</td>
<td></td>
<td>2.0</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>4.9</td>
<td>5.0</td>
<td>6.2</td>
<td>7.0</td>
<td>8.5</td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td>5.0</td>
<td>6.0</td>
<td>8.9</td>
<td>-</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>2.7(^e)</td>
<td>4.8</td>
<td>7.8</td>
<td>7.5</td>
<td>14.0</td>
</tr>
</tbody>
</table>

\(^a\)These are estimates from separate sources and are probably not directly comparable.

\(^b\)From K. Bruun et al., *Alcohol Control Policies in Public Health Perspectives*, vol. 25 (Helsinki, Finland: The Finnish Foundation for Alcohol Studies, 1975). 56, selected countries from Table 10.

\(^c\)From J. Moser, ed., *Alcohol Policies in National Health and Development Planning* (Geneva: World Health Organization, 1985). Numerical consumption statistics presented here were estimated from graph in Figure 5, page 18.


\(^e\)Estimates.

\(^f\)Much of this increase is thought to be a consequence of increased consumption by tourists.
The overall worldwide growth rate in per capita consumption over the past two decades has averaged 1.5 percent annually, but these official consumption data may misstate real levels. They miss some nonmarket (or “moonshine”) production as well as other consumption that goes unrecorded because it falls outside a nation’s formal economy. This question of the relative contribution the formal and informal production sectors make to rising consumption rates in the developing world remains the subject of considerable scholarly debate and public policy importance. Global data are also deficient; they mask important differences across nations and cultures, and they are sketchy at best. Exhibit 1 summarizes consumption data from three of the few available published sources. Impressions of international observers indicate that rates of increase in western European and North American countries have been leveling off relative to sharp increases in some developing countries, particularly in the African and Latin American continents. The newer recruits to the ranks of “wet” countries began at a lower base rate but are experiencing inclines so steep as to warrant serious concern.

Even in some predominantly Moslem countries, where alcohol has been proscribed in the teachings of the Prophet Mohammed, increasingly it is being viewed by informed health professionals as an inchoate threat. In Jordan and Egypt, for example, alcohol abuse is not yet the problem that other drugs are perceived to be. But health advocates there are anxious to institutionalize controls on alcohol now, while the climate is still receptive and before serious difficulties develop.

Meanwhile, France illustrates that the “wet” Western world can hit a plateau in consumption. In the World Health Organization (WHO) European region, France, with the highest consumption rate, has exhibited the most distinct and sustained decline in consumption. Although several factors are at play in France, a persistent, well-researched, culturally specific, and thoughtful publicity campaign is also believed to have played a role. Mounted by the government in an effort to contain rising rates of cirrhosis of the liver, the French campaign suggests that the Western countries can engineer a change in overall drinking patterns.

More recently, less by persuasion than by fiat, the government of the Soviet Union attempted strong anti-alcohol measures, experienced the inevitable tradeoffs that such policies entail, and relaxed them officially. Although the potential savings in health and productivity were expected by the Soviet regime to outweigh any costs of limiting the availability of alcohol, restricting official sales apparently stimulated growth in moonshine production and created such social tensions as to render draconian restrictions on sales politically untenable. Behind this judgment, as behind many an alcohol policy, lies the implicit cost-benefit calculus that
Kettil Bruun identified in his studies of Sweden, where, in the 1920s “many were ready to sacrifice a great deal” to rid the nation of this “dangerous drug.”

**Economic Versus Health Considerations**

Tradeoffs between individual liberty and social control are one source of tension in alcohol policy; another derives from conflicts between health and economics in the international balance of trade. Issues arising here are becoming especially contentious as affluent populations in the developed world begin to pursue physical fitness and “healthy lifestyles,” reducing their demand for alcohol and diverting to less-developed nations the principal untapped markets for growth in alcohol sales. Around the world, the need is urgent for better integration of the economic and health perspectives on alcohol, and for amplification of the often-overwhelmed health theme.

But as strong as the tensions are between commerce and health, the tradeoff is far from simply unidimensional, with health factors weighing for state control and commercial ones weighing against. The attempted Soviet strictures on drinking, for example, seemed principally inspired by economic considerations; specifically, by the perception that alcohol abuse undermines productivity and industrial development. Employee assistance programs in American corporations rest on similar logic. Moreover, the state’s own economic interests can cloud its health concern, as reportedly occurred in Finland, where the 1932 transition from prohibition to nationalization of the alcohol trade was partly driven by the pressing need for generating funds to support social security and industrialization. To nationalize the alcohol beverages industry was to rechannel revenues from private, illegal hands into the state treasury. Secondarily, it provided a lasting mechanism that could be used in the service of public health to control many phases of production, distribution, and sales of alcoholic beverages.

Even in small, homogeneous cultures with a tradition of government control, both economic and health considerations can yield to wider social forces. Finland began gradually to liberalize its alcohol policies halfway through this century, pressured by perceived inequalities in the burdens they imposed on rural residents and on women. As an urban middle class began to emerge, new types of outlets were licensed, new alcoholic beverages became available, hours of sales were expanded, and limited advertising was instituted. Consumption rates began to climb after 1960, jumped by about 50 percent in 1969, and climbed steadily thereafter. By the 1970s these trends were exacting a heavy price in social
disorganization and mortality from cirrhosis of the liver. Policies were then established to prevent continued growth in consumption, with some success.  

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Understanding Alcoholism As A Disease

By 1975, a World Health Organization scientific working group was redefining the alcohol problem in public health terms. Their report was followed, in the United States, by an influential document from the National Academy of Sciences, exploring from the standpoint of American alcohol policy the implications of a public health orientation. The public health approach highlighted the need for policies designed to reduce overall consumption of alcohol, so that rates of associated problems would in turn decline. Known as the “single distribution” or “total consumption” theory, the empirical observation stimulating this re-conceptualization was developed originally by Sully Ledermann in 1956. Ledermann had challenged the shibboleth that the alcohol problem is isolated in a small group of “alcoholics,” fundamentally different from the rest of a population. He showed that alcohol use is best represented along a single distribution curve (the “Ledermann curve”) and does not exhibit the bimodal pattern that would signal a sharp disjunction between “normal” and “problem” drinking. For policy, this implied that changes in overall per capita alcohol consumption could produce changes in the numbers of heavy drinkers. It would follow that alcohol control measures, such as taxation and legal restrictions on supply and demand, should reduce consumption and related problems.

Ledermann’s theory provoked lively discussion among both critics and converts; it served as the chief rationale for public health advocates to expand upon a disease model of alcoholism that had provided the “governing image” of alcohol problems after the temperance movement had foundered in the early 1930s. “Any alcoholism program must have a preventive as well as a curative component,” a subsequent WHO document began. “Alcoholism or alcohol dependence is only part of alcohol-related problems, and alcoholism cannot be tackled without a policy toward the agent, alcohol.” The political sensitivity of the proposition was telegraphed in the working group’s observation that “alcohol is a drug which, in every sense, excites passions.” Appreciating the drama behind that terse statement requires an understanding not only of how entrenched the medical model of alcoholism had become in the United States and around the world, but also of the long struggle involved in establishing alcoholism as a disease.

The physician/statesman Benjamin Rush was the chief originator of
the disease concept in the United States. In 1785 he wrote in a famous and widely circulated tract that those who “lost control” of their drinking suffered from the “disease of inebriety,” the behavioral symptoms of which he catalogued in vivid detail.\textsuperscript{14} Rush and subsequent advocates of the disease model were motivated partly by the desire to shield the drinker from the harsh blame that characterized prevailing legal responses to public drunkenness. But in the eyes of the temperance movement liquor was the problem, the agent of this disease and a categorical evil so destructive that no measures against it were too harsh.

When temperance thinking gave way to the forces of modernization, some scholars have argued, the disease concept resurfaced to function as a device (an “alibi”) deflecting attention away from liquor itself and toward the especially sensitive alcoholics infected by the disease.\textsuperscript{15} Defining the control problem chiefly in terms of treatment and placing major responsibility for the alcohol problem with the medical profession allowed the alcohol trade to flourish in the wakening consumer era. By definition, the alcoholic’s behavior, controlled as it was thought to be by dependence on alcohol, would be utterly impervious to attempts by the state to regulate the overall sale or use of alcoholic beverages.

From Rush’s day on, the disease model was advanced in a spirit of optimism about possibilities for cure. Advocates of the disease concept coalesced into an organized social movement, channeling new energy and resources into therapeutic programs. These have grown and prospered, especially in the United States in recent decades, with the continued expansion of the alcoholism movement, buttressed by the welfare state. But evidence so far from controlled research casts doubt on how much can be expected from further escalation of treatment strategies. Studies consistently suggest that the more intensive, expensive, high-technology approaches produce results in no way superior to far simpler interventions.\textsuperscript{16}

With this in mind, WHO is currently sponsoring an eleven-country evaluation of simple treatments. What remains to be sorted out is which treatments are themselves successful or unsuccessful and in which instances failure to identify treatment impact may be a function of methodological limitations. Few treatment studies to date have accrued sizable enough samples to explore interaction effects, and few have followed subjects over the extended periods of time that a chronic condition such as alcoholism warrants.

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**The Role Of Physicians**

In spite of the shortage of data, there is limited empirical evidence and
a great deal of clinical experience indicating that some treatment is preferable to none for those who find their way to organized programs.\textsuperscript{17} Many alcoholics do recover, and motivation seems crucial in the process, as does some kind of external pressure or control mechanism.\textsuperscript{18} Alcoholism may usefully be approached as a chronic disease such as diabetes, the effective management of which requires self-administered treatment on a continuing daily basis. Prevention of relapse is the cardinal challenge faced by clinicians and patients alike.

That challenge surfaces, however, only after a first-order one—the initial identification of a problem—has successfully been met. It is commonly accepted now that some 20 to 30 percent of patients seeking care from primary physicians have some background of alcohol abuse, mostly undetected.\textsuperscript{19} Evidence is building that primary physicians seriously underestimate the prevalence of problem drinking among their patients and often neglect even to discuss drinking with patients whose alcohol problems are salient enough that they reveal them to survey researchers.\textsuperscript{20}

One study of 400 Boston-area physicians confirmed their tendency to overlook their patients’ drinking, ascertained that few had been exposed to even rudimentary training in how to detect and treat alcoholism, and identified wide gaps in knowledge of the disease as well as in ability or inclination to treat it.\textsuperscript{21} The U.S. federal government (through the national institutes of alcohol and drug abuse) is seeking to stimulate fuller coverage in medical school curricula of material on the clinical detection and management of substance abuse in the practice of family medicine, internal medicine, pediatrics, and psychiatry.\textsuperscript{22} A young Israeli physician at the Salzburg Seminar in 1986 who observed that he learned in his medical training to define an alcoholic “as someone who drinks more than his doctor” may have been speaking for many of his professional colleagues around the world.

The semantics in even establishing a diagnosis are tricky because alcoholism is characterized by the number and frequency of problems rather than by any specific indicator. There is a broad gray zone, as one psychiatrist in Salzburg observed, separating “normal drinkers like us from alcoholic drinkers like them.” Progress is being made in the development and validation of more effective methods of detection, using biological markers in conjunction with data obtained in clinical history taking.\textsuperscript{23}

Internationally, WHO has been sponsoring a six-country collaborative project seeking to devise better instruments for identification of individuals whose alcohol consumption is harmful or puts them at high risk.\textsuperscript{24} This builds on previous work, including some in the United States, where a simple questionnaire, known by the acronym CAGE, has been demon-
strated more sensitive and specific than a battery of liver function and blood tests.\textsuperscript{25} It involves asking patients whether they have ever felt they should cut down on their drinking, or felt annoyed by criticisms of it, or guilty about it, and whether they have ever had a drink as an eye opener, first thing in the morning. Combined with a series of five items eliciting an adult history of trauma, these questions can be woven into the taking of a patient’s history.\textsuperscript{26}

Improving techniques for early detection may identify problems at an earlier stage when they should be less intractable. In the Alcoholics Anonymous (AA) lexicon, this mirrors the concept of “raising the bottom” that the alcoholic may ultimately hit. Because alcoholism is a disease of denial, recovery begins with the recognition born of “hitting bottom,” which stereotypically implies the equivalent of waking up on Skid Row. Intervention programs—such as those sponsored by unions and employers, and more recently those in schools and primary care practices—re designed to manufacture an earlier confrontation and a self-assessment that would coax problem drinkers into treatment before their alcohol abuse has continued for a long time and gradually eroded all of their social support systems in the family, in the community, and at work. Here again, the supporting logic is persuasive, and researchers are beginning to seek substantiation from credible empirical studies that these strategies actually work.\textsuperscript{27}

**Diversified Control Strategies**

As empirical data on the nature of the alcohol problem have accumulated, the narrow model of alcoholism as a unitary disease has yielded to a more complicated picture of various stages of alcohol involvement, types of use and abuse, and a wide range of associated problems.\textsuperscript{28} The pivot for the transition from a narrow medical model to a more encompassing public health approach, this more variegated view of the alcohol problem underlines the need for an equally diversified set of control strategies. These are summarized in the framework in Exhibit 2, which organizes policy options according to the public health rubric of host, agent, and environment. Several reviews are now available of experiences in the application of such strategies in the United States and around the world.\textsuperscript{29}

Public health thinking enlarges the scope of concern to encompass morbidity and mortality in all different forms, not only the illnesses directly related to the physical or psychological impact of alcohol abuse. It thus implicates a broader range of high-risk drinking; Also, a public health approach conveys a philosophy concerning how best to intervene. It incorporates the belief that, contrary to conventional wisdom, imper-
### Exhibit 2
A Conceptual Framework For Comprehensive Alcohol Policy

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Target</th>
<th>Agent</th>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legal (behavior)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct via sanctions</td>
<td>Drinking age; public drunkenness laws</td>
<td>Prohibition</td>
<td>Driving while intoxicated laws</td>
</tr>
<tr>
<td>Indirect via market</td>
<td>Mandatory financial penalties for alcohol abuse</td>
<td>Taxes on alcohol; product liability</td>
<td>Third-party liability suits versus purveyors of alcohol (dram shop)</td>
</tr>
<tr>
<td>Indirect via persuasion</td>
<td>Mandatory alcohol education programs</td>
<td>Regulation of alcohol advertising labeling requirements</td>
<td>Statutes requiring protection of drinkers (from themselves and others from them)</td>
</tr>
<tr>
<td><strong>Market (incentives)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supply side incentives</td>
<td>Rewards for not selling to vulnerable populations</td>
<td>Rewards for alternative production</td>
<td>Rewards for making the world safer for drinkers and those around them</td>
</tr>
<tr>
<td>Supply side disincentives</td>
<td>Penalties for marketing to vulnerable populations</td>
<td>Penalties for producing alcoholic beverages</td>
<td>Penalties for absence of protections</td>
</tr>
<tr>
<td>Demand side incentives</td>
<td>Rewards for not abusing alcohol</td>
<td>Rewards for not purchasing alcohol</td>
<td>Rewards for using safety precautions (such as seatbelts)</td>
</tr>
<tr>
<td>Demand side disincentives</td>
<td>Penalties for abusing alcohol</td>
<td>Penalties for purchasing alcohol</td>
<td>Penalties for failing to take safety precautions</td>
</tr>
<tr>
<td><strong>Education (beliefs)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual (parent to child, physician to patient); Organizational (workplace, schools, churches); and Community (mass media campaign)</td>
<td>Messages: “Responsible drinking,” resisting peer pressure to drink</td>
<td>Messages: How much is too much; health, psychological, and social consequences of alcohol abuse</td>
<td>Messages: Don’t drink and drive; don’t ride with drunk drivers</td>
</tr>
<tr>
<td></td>
<td>Focus: Individual motives and choices</td>
<td>Focus: The substance of alcohol and its effects</td>
<td>Focus: Situations in which alcohol use combines with the environment to engender high risk</td>
</tr>
</tbody>
</table>


Personal approaches to a problem such as alcoholism are as important as personal ones that require ongoing cooperation and motivation. Studies are demonstrating that increasing the price of alcohol does decrease both consumption and problems such as cirrhosis and accident rates. Specific legal interventions, such as raising legal drinking ages, and tough laws sanctioning driving while intoxicated can be effective under the right circumstances.\(^\text{30}\)

The proposition favoring impersonal controls remains difficult to accept, not only in the United States but around the world. If lives are saved by tax policies set at the aggregate level, these lives are only
statistical abstractions. We can never know which individual who had a propensity to abuse alcohol was deterred by a well-designed tax policy, nor, when puzzling over someone whose life has been destroyed by alcohol, is it easy to accept as explanation that the price was a little too low. There is always an enormous tension between patterns in populations and the personal experience that carries so much weight.

**Extrapolations For The Future**

The evolution around the world to a broader public health conception of alcohol control partly reflects growing sophistication about complexities and subtleties of alcohol use and abuse problems. But also, ideologies about alcohol continue to be driven by larger social and economic forces. The building pessimism about treatment efficacy, for example, is being fueled to a considerable extent by political pressures associated with the costs of supporting the welfare state; economics are again reshaping public thinking about the alcohol problem. The disease model of alcoholism that gained currency around the world through the 1960s and into the 1970s was strongly supported by the influx of resources worldwide in support of social welfare programs. As that support is drawn back, and a “public health” approach to alcohol is advanced as an alternative to the disease model, the policy question must be asked, in the context of a shrinking welfare state, where the responsibility will reside for conserving the public’s health, and how resources will be found to treat the casualties. A broad definition of public health includes a commitment to treat disease; public health thinking need not be set in opposition to an understanding of alcoholism as a disease warranting medical treatment.

**Practical issues.** Beyond this fundamental philosophical question lie practical issues needing attention as well. The lesson for U.S. alcohol policy from an international perspective is how sensitive control strategies must be to a given culture. Because of their melting pot legacy, Americans will delude themselves if they look for an omnibus or simplistic solution to alcohol abuse. Some potential drinkers will be sensitive to price controls, and some will be influenced by educational programs in the schools or through the mass media. Some problem drinkers will be helped by Alcoholics Anonymous, others by more medical approaches, and some will perhaps fare best if they are hospitalized for a time.

Certainly the way problems manifest themselves varies with the culture. In countries where young people have no access to automobiles, legal drinking age laws make little sense. The Finn who drinks explosively during the short summer’s revelries or the Pole who drinks on name days...
pose different challenges than do the nightly pub culture in the United Kingdom or the ubiquity of wine with meals in southern Europe. Alcohol-fueled hooliganism at football games in England and Australia and peace-keeping problems at Oktoberfest in Germany raise special issues, as does alcohol-related absenteeism in industrial workforces around the world.

In the face of all this complexity it seems almost facile to say that more research is needed. But if alcohol policies are to be effective, much more effort will be required to separate the alcohol problem into its component parts and to lay the groundwork for a targeted and diversified, but integrated, set of control strategies on the national and international levels. Meanwhile, one rule of thumb is to avoid oversimplification. The enemies of the public health perspective are two orthogonal ideas: first, that alcohol is immoral per se, and second, that there is nothing wrong with alcohol per se. Each idea has shaped policy in one place and time or another; neither is sufficiently subtle to inform effective policy anywhere.

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